Mr Richard PEASE
MB, BS, (Lond), FRCS, FRCSE
Orthopaedic Surgeon

27 February 2023

STRICTLY PRIVATE & CONFIDENTIAL

GIO Workers Compensation - Tasmania
GPO Box 1136
Hobart TAS 7001

Attention: Riyadh Addicoat

Dear Mr Addicoat,

INDEPENDENT MEDICAL REPORT

Re:	**Elizabeth KIEL**	
Claim Number:	**G5084789**	
DOB:	12 April 1962	Age: 60 years
Occupation:	Educator	
Employed by:	Goodstart Early Learning	
Date of Injury/Accident:	9 July 2018	

INTRODUCTION

Thank you for asking me to see Ms Kiel, whom I examined at Level 8, 459 Little Collins Street, Melbourne on 17 February 2023.

This examination was undertaken via a NEXUS telehealth assessment with the examinee being in a different location to the consultant. Consent is obtained electronically for NEXUS telehealth assessments.

During interview, she was alone in the consulting room.

I confirm that I have read the Expert Witness Code of Conduct and agree to abide by it.

I explained that I was an independent orthopaedic surgeon and as such would not be providing commentary on her situation.

DOCUMENTATION

1. Worker claim form dated 10 July 2018
2. Ultrasound right shoulder dated 10 July 2018
3. Surgery request letter by Mr David Penn dated 03 March 2020
4. Medical Report by Dr Venter dated 14 April 2020
5. Medical Report by Mr Stanley-Clarke dated 18 June 2020
6. Medical Report by Dr Daniels dated 19 July 2020
7. Various Medical certificate
8. Letter from Physiotherapist Ms Sally McLaine dated 19 April 2021
9. Medical Imaging Report , dated 3 May 2021
10. IME report by Dr Peter Dodd dated 1 July 2021
11. Medical Report by Mr David Penn dated 21 February 2022
12. Medical imaging report dated 7 June 2022, 4 July 2022
13. Psychologist Letter dated 9 June 2022
14. Letter from Dr David Penn dated 11 August 2022
15. Physiotherapy Assessment and Treatment Plan
16. Sensory Nerve conduction study dated 5 December 2022
17. Operation Record dated 3 March 2020

I acknowledge receipt of the documents you sent me, unfortunately, some were illegible.

CLINICAL HISTORY

Ms Kiel told me that she was a qualified child educator and injured her right shoulder during the course of her employment with Goodstart Early Learning in Launceston.

She first injured her right shoulder in 1995, when a child jumped from a slide and pulled Ms Kiel's right arm. 'My arm pulled down as I went down.'

Her shoulder remained symptomatic. She had a labral repair undertaken in Launceston, from which only partially recovered.

She then had a manipulation and possibly an arthroscopy in 1997, without any benefit.

In 2009, she had a manipulation and arthroscopy at St Luke's Hospital in Launceston. She recovered well from this procedure and returned to all of her normal activities without any discomfort. She mentioned kayaking and stated that she was able to lift and drive without any difficulty.

She suffered a further injury on 5 December 2016, when she fell at work. She was working with infants when she noticed that one child was on top of another, biting the one underneath. She ran across to protect the infant. In doing so, she developed pain in her shoulder.

She was away from work for a period of time.

She saw a specialist, possibly Dr or Mr Butoroc (as she spelled it).

She subsequently undertook a physical exercise program with exercises in the pool and in a gymnasium. She also had physiotherapy.

She told me that she recovered completely and resumed all normal activities including kayaking, swimming, work, and household duties.

On or about 9 July 2018, she sustained a further injury to her right shoulder when working in a baby room.

When carrying a baby in her left arm, she tripped on a toy. 'Whilst I was trying to balance myself, I fell on my right arm. I fell on my right arm so I didn't fall on the baby.'

She experienced severe pain in her right shoulder. 'I was laying on the ground. An educator came and got the baby, I was screaming. I felt like a pull in my shoulder. The pain was extreme.'

She attended her general practitioner, Dr Venter. The doctor has provided a letter dated 14 April 2020, in which she records the incident and notes a final certificate dated 28 September 2019.

Ms Kiel told me that she continued to complain of severe pain and disability. She self-funded physiotherapy and hydrotherapy, which did not bring about any improvement in her situation.

She was referred to Mr Penn, an orthopaedic surgeon in Launceston.

He referred her for x-rays and an MRI and diagnosed a torn rotator cuff with 'a very thick tear which needed operation.'

At this stage, she had severe pain in her shoulder, to the point where she was not able to sleep. She was finding it very difficult to drive, she was not able to clean or care for herself, except by using her left hand and arm.

She had surgery and was discharged from St Luke's Hospital Launceston in a sling. She noted that she had significant pain after the operation, 'I did not progress as fast as everyone had hoped I would despite doing physiotherapy regularly. I worked very hard in the pool.'

Perhaps eight weeks after that operation, she suffered a further injury to her shoulder when she was dressing. As she was putting on her clothes, she experienced an excruciating pain in her shoulder. She had another operation in March 2020.

The operation note described an interscalene block.

The findings were of a 'biceps tendon degenerate tear, rotator cuff - supraspinatus - anterior full-thickness tear. Subacromial impingement, acromioclavicular joint osteoarthritis.'

The surgeon performed an arthroscopic bursectomy and subacromial decompression with a shaver and a burr. The distal clavicle was excised, with a bicipital tenodesis and a double-row repair.

She did not recover, complaining of persistent pain in her right shoulder with reduced movement and associated problems.

She self-managed the situation using ice and heat, exercise, and physiotherapy.

She returned to Mr Penn, who 'looked at it and said, "There's nothing else I could do." He said, "It's a failed rotator cuff, I can't do anything but to do a salvage procedure with a shoulder replacement."'

She had another MRI and persisted with her physiotherapy and hydrotherapy, but on 24 April 2022, she underwent a reverse shoulder arthroplasty at St Luke's Hospital in Launceston at the hands of Mr Penn.

She was in hospital for four days and was advised to undertake gentle movement exercises on discharge.

Subsequent to her operation, in addition to the pain and disability in her right shoulder, she had excruciating pain 'at the back of my neck. My arm felt different, I had tingling in my fingers, I could not feel my fingers, I could not move my fingers properly, I could not feel my arm.'

She was investigated, including by MRI, and was told that she had damage to her brachial plexus. 'I could not feel my arm. I could not move it. I still can't move it.'

Nerve conduction studies have shown abnormalities but that 'the myelin was recovered.'

She has continued with conservative management since, which has included TENS, ice, heat, physiotherapy, and hydrotherapy.

She complains of the following problems:

1. Constant pain in her right shoulder. Her shoulder pain is aggravated by trivial actions such as taking a deep breath.

2. Almost no movement in the shoulder. 'I can't move it, it is really, really painful. When the physiotherapist moves it for me, it is really painful.'

   When she moves her shoulder, 'it feels as though something is jamming in the joint'.

3. She finds it very difficult to sleep. In bed she places a pillow under her right armpit.

   If she wakes at night, she has a sensation as though something is 'stuck' in her shoulder. She has to move it.
   She cannot sleep on her right side. If she rolls onto her right side during her sleep, she wakes.

   She estimates that she does not get more than three hours' sleep at a time during the night.

   If her pillow dislodges or moves, 'I yell in pain.'

4. She cannot reach out with her arm. She cannot open her car door with her right arm and hand.

5. She has significant difficulty dressing. She does her bra up in front, but when she moves her right arm to adjust her bra or other items of clothing, she experiences severe pain in her right shoulder.

6. The shoulder is painful when she is showering and undertaking personal activities. Using a towel makes her shoulder very sore. 'I can't wipe my backside.'

7. Her shoulder becomes more painful in hot weather. In cold weather, her hand 'changes to a different colour.'

8. If her right arm hangs by her side, she experiences pain and a sensation of heaviness, to the point where when she is walking or otherwise moving, she puts her right hand in her pocket.

9. She has an unusual feeling in her fingers, 'like they don't belong to me.'

10. When she is in the hydrotherapy pool, pressure on her right hand and arm feels different to her left hand and arm.

11. Her right grip is weak, to the point where she often drops things.

12. On the Monday before I saw her, a physiotherapist tried an exercise with her holding a 2 kg kettle in her right arm. This caused severe pain in her arm and neck, which persisted for two days and had not settled when I saw her.

13. If she turns her neck to the left, she experiences pain radiating from the right side of her neck into her arm.

14. She cannot write using her right hand. She cannot use a knife and fork.

15. She is unable to flex her fingers with her forearm supinated, but she can, with some difficulty, when her forearm is pronated.

16. She has become very depressed as a consequence of her pain and disability.

She denied any other symptoms on direct questioning and told me that she was right-handed by nature.

PAST HISTORY

She injured her left hand many years ago when playing hockey. This required a tendon repair.

Ten days before her first shoulder operation, she suffered a meniscus injury when dancing the can-can. She had a successful arthroscopic procedure.

TREATMENT

Treatment includes asthma medication in addition to perhaps an analgesic at night. She uses a TENS machine.

WORK

She has not been able to return to work since her shoulder-joint replacement.

She described a wide range of difficulties in relation to her housework.

She can use a light stick vacuum in her left hand, but she cannot do any heavy work.

SOCIAL

Her partner is a social worker. She has a 32-year-old daughter, who is a general practitioner, and a 34-year-old son.

She has not been able to resume any of her previous social activities. For instance, if she and her partner go out for a meal, she orders items which are soft and can be managed with a fork in her left hand. She is embarrassed if her partner has to cut food up for her.

Sport

Prior to her injury, she was a very 'outdoors person.' She enjoyed kayaking, camping, bushwalking, and similar activities. The couple have a shack on the east coast of Tasmania where she has not been for 13 months because the road is bumpy and makes her shoulder pain worse.

PHYSICAL EXAMINATION

It is not possible to undertake a physical examination in the context of a NEXUS assessment, but Ms Kiel stood in front of the camera and demonstrated her range of movement, which was limited in the extreme. It appeared that she did not have more than 10 degrees of abduction and flexion. There appeared to be no extension or adduction. I could not estimate internal or external rotation.

MEDICAL IMAGING

An ultrasound was performed on her right shoulder on 10 July 2018.

The radiologist's conclusion was: 'Swelling and decreased echogenicity of posterior supraspinatus tendon in keeping with tendinitis. Osteoarthritic changes of the AC joint are noted as well.'

Dr Kate Daniels undertook a radiology review dated 19 July 2020. An x-ray of the right shoulder dated 2 April 2019 was essentially normal.

An ultrasound of the right shoulder dated 7 April 2009 was essentially normal, except for a suggestion of mild tendinosis in the supraspinatus tendon.

An MRI of the right shoulder dated 5 August 2009 suggested early acromioclavicular arthropathy but no abnormalities otherwise.

An ultrasound of the right shoulder dated 16 December 2016 suggested mild hypo-echogenicity and heterogeneous texture of the anterior supraspinatus, slightly more pronounced than seen in 2009, consistent with tendinosis.

An x-ray of the right shoulder dated 30 January 2017 was normal.

A further x-ray of the right shoulder, dated 16 April 2019, did not reveal any evidence of an arthropathy but mild degenerative changes of the acromioclavicular joint were noted.

An ultrasound of the right shoulder dated 10 July 2019 revealed 'persistent thickening and heterogenicity of the supraspinatus tendon but no tear is identified.'

An ultrasound of the right shoulder dated 20 September 2019 revealed a possible partial-thickness tear of the supraspinatus tendon.

An MRI of the right shoulder dated 16 December 2019 noted progressive degenerative change by way of acromioclavicular joint osteoarthritis with subchondral sclerosis, subchondral cyst and small marginal osteophyte and a small effusion. The long head of biceps tendon was majorly dislocated, consistent with biceps pulley disruption. There were changes consistent with interstitial tearing of the biceps tendon. There appeared to be intrinsic tearing in the supraspinatus tendon suggestive of a partial-thickness tear.

The radiologist commented: 'Between the ultrasound in July 2018 and the MRI on 16 December 2019, there is progressive supraspinatus tendinosis and the development of an anterior supraspinatus tendon tear that was first appreciated on the 2019 ultrasound. The interstitial supraspinatus and infraspinatus tendon tears would not have been detectable with the ultrasound, so it is possible that they had been present at the time of the 2018 and 2019 ultrasounds, but occult.'

OPINION AND PROGNOSIS

Ms Kiel gives a history of previous shoulder injuries, from which she had recovered, with or without surgical treatment.

In 2018, she sustained an injury to her right shoulder, from which she did not recover and has not recovered since.

She described two arthroscopic procedures followed by a reverse shoulder arthroplasty.

In addition to her shoulder problems, she has significant neurological symptoms and disability in relation to her right arm. This may be related to the interscalene nerve block which is recorded in the operation note. The neurological manifestations in her right arm are not a direct consequence of the shoulder injury, other than the fact that they appear to have presented after her shoulder joint replacement operation.

With regard to this problem, it would be appropriate for her to have an assessment and examination by an independent neurologist.

RESPONSES TO SPECIFIC QUESTIONS

With regard to the questions raised in your letter of 9 February 2023:

1. *What were the symptoms and what clinical findings did you note upon your examination?*

   Ms Kiel's symptoms are described, as are my observations on her shoulder joint movements during our interview.

2. *What is your diagnosis?*

   She has a failed right shoulder arthroplasty in addition to significant neurological symptoms and disability in her right arm.

3. *What are your short- and long-term prognosis'* [sic]*?*

   Both short- and long-term prognoses are extremely poor.

   I do not believe that any treatment is likely to improve her situation.

   There is no indication for any further surgery.

   An opinion on the neurological prognosis in her right arm should be sought from a neurologist.

4. *Are you satisfied that any symptoms reported are still related to the work injury and the procedures? Are there any other contributing factors?*

   I am satisfied that her reported symptoms are related to the work injury and the procedures.

   There are no other contributing factors.

5. *What is Mrs Keil current capacity for work? If applicable, please specify any restrictions on hours.*

   She has no capacity for work.

   As indicated in the body of this report, she cannot eat with a knife and fork, she cannot write, her housework activities are limited in the extreme.

6. *If your view is that Mrs Kiel is completely unfit for her normal duties, do you believe she may be able to partake in host placement or alternative duties?*

   Ms Kiel's symptoms and disability appear to be so severe that I do not believe that she would be able to partake in host placement or alternative duties.

7. *What further treatment do you feel may be necessary in the future because of the work-related injury? Please comment on the number of future sessions if further physiotherapy treatment is required.*

   She should continue with her physiotherapy and hydrotherapy into the indefinite future. This might preserve what little movement she has and perhaps provide some degree of comfort. Two sessions a week of hydrotherapy and physiotherapy would be appropriate into the indefinite future.

8. *Has the Miss Kiel now reached maximum medical improvement from this workplace injury on 9 July 2018 and following surgeries?*

   I believe that she has reached maximal medical improvement from her workplace injury and following surgeries.

9. *What, if any, whole person impairment would you place?*

   Using the 4th Edition AMA Guides as an indicator, her total shoulder arthroplasty rates a 30% whole person impairment.

   The neurological problems in her right arm should be assessed by an appropriate independent neurologist.

10. *Any further comments you consider to be of interest or of relevance in relation to this matter.*

    She has become depressed as a consequence of her pain and disability. I am not qualified to make any further comment on this part of her presentation.

Yours sincerely,

Mr Richard Pease
MB, BS, (Lond), FRCS, FRCSE
Orthopaedic Surgeon